

#  Group Information

Group Legal Name:

Group DBA Name:

Group NPI Number:

Fax Number:

Fax Number:

Fax Number:

Tax ID:

Specialty of Group:

Primary Service Address:

Phone Number:

Secondary Service Address:

Phone Number:

Billing Address:

Phone Number:

# Office Contact

Office Contact Name:

Office Contact

Phone:

Office Contact Email:

#

#  Provider(s) Information

Provider Name:

Provider NPI Number:

Social Security Number:

Date of Birth:

Primary Specialty:

Secondary Specialty:

Board Certified:

Name of Certifying Board:

Provider Type PCP \_\_\_\_ Specialist \_\_\_\_ Both \_\_\_\_



**Documents Required for Credentialing Purpose:**

* W-9 Form
* IRS Letter (CP 575)
* State License
* DEA Certificate
* CDS Certificate (If applicable)
* CLIA Certificate (if applicable)
* Residency Diploma
* ECFMG Certificate (If foreign graduate)
* Board Certification (If applicable)
* Professional Liability Insurance Certificate
* Hospital Affiliation
* Collaborative Agreement

|  |  |  |  |
| --- | --- | --- | --- |
| Portal Name  | Username  | Password  | Associated E-mail  |
| PECOS, NPPES, I & A  |   |   |   |
| CAQH  |   |   |   |



# Insurance Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sr#  | Insurance Name:  | Already Enrolled  | Provider ID  | Want To enroll  |
| 01  |   |   |   |   |
| 02  |   |   |   |   |
| 03  |   |   |   |   |
| 04  |   |   |   |   |
| 05  |   |   |   |   |
| 06  |   |   |   |   |
| 07  |   |   |   |   |
| 08  |   |   |   |   |
| 09  |   |   |   |   |
| 10  |   |   |   |   |
| 11  |   |   |   |   |
| 12  |   |   |   |   |
| 13  |   |   |   |   |
| 14  |   |   |   |   |
| 15  |   |   |   |   |
| 16  |   |   |   |   |
| 17  |   |   |   |   |
| 18  |   |   |   |   |
| 19  |   |   |   |   |
| 20  |   |   |   |   |

All information provided to MedICD is filled out to the best of your knowledge and completely accurate

Signature:

Print name:

Role in medical faculty/ Office: